| Requirement Source | The Requirement | The Integrated Health Home (SPMI) SPA IA-22-0004 |
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| **General Assurances - States Must Assure That:** | | |
| Consolidated Implementation Guide: Medicaid State Plan – Health Homes | Eligible individuals will be given a free choice of Health Homes providers. | Page 7 IME attests that they are given a free choice. Page 26 Member must choose between Health Homes and cannot be in more than one at a time. |
| | Individuals who are dually eligible for Medicare and Medicaid will not be prevented from receiving Health Homes services. | Page 7 IME attests that they are not prevented from receiving Health Home Services. |
| | There will be no age restrictions and that Health Homes services will be made available to all individuals who meet the eligibility criteria. | Pages 6 & 7 population criteria includes individuals of all ages. |
| | Participating hospitals will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers. We expect that states will need to communicate with hospitals and other stakeholders on the expectations for referring eligible individuals to a Health Home. We interpret this section to mean that hospitals will work with Health Homes to make referrals and to provide timely medical information on potential or current Health Homes enrollees who have received medical treatment at the hospital, whether through emergency room or inpatient admissions.<br><br>Health Homes providers must develop a working relationship with hospitals to assure that information is shared and communicated efficiently to all community providers. | Pages 7 & 8 IME attests to this and is written in Iowa Administrative Code 77.3(2) Referral to health home services provider. As a condition of participation in the medical assistance program, hospitals must establish procedures for referring to health home services providers any members who seek or need treatment in the hospital emergency department and who are eligible for health home services pursuant to 441—subrule 78.53(2). https://www.legis.iowa.gov/docs/iac/chapter/441.77.pdf |

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| | FMAP for Health Homes services shall be at 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.<br><br>The state will have systems in place so that only one 8-quarter period of enhanced FMAP for each Health Homes enrollee will be claimed. | Page 8 IME attests that we claim the regular match rate as we are past the first 8 quarters. |
| | There will be no duplication of services and payment for similar services provided under other Medicaid authorities. States with one or more existing care management program must assure that there will be no duplication of services and no duplicate payment for the same services as those provided through the Health Homes program.<br><br>The description of how the state will not be duplicating payment in its Health Homes program for the same or similar services offered/covered in a different program or under another statutory authority should be sufficiently clear, detailed, and complete to permit the reviewer to determine that the state's approach meets applicable federal statutory, regulatory and policy requirements and should include:<br><br>• The manner in which the state will identify health homes services to ensure that there will be no duplication of services and payment for similar services provided under other Medicaid authorities, including whether billing and payment is handled through MMIS and how | Page 8 IME attests that there will be no duplication in payment.<br><br>Page 21 it is noted that IME included this language in the MCO contract.<br><br>Page 26 IME describes how it ensures non-duplication for similar (1915i Habilitation program and concurrently enrolled in a 1915c waiver program). |

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| | the State will track billable services if claims are not submitted through the MMIS. | |
| **Health Homes Population** | | |
| Consolidated Implementation Guide: Medicaid State Plan – Health Homes | **Geographic Limitations**<br>In this section, indicate if the services for this Health Homes programs will be provided statewide from the beginning, permanently limited to certain geographic areas, or phased-in by geographic area to eventually be statewide. | Iowa indicated statewide. |
| Federal Code SEC. 1945. **[**42 U.S.C. 1396w-4**]** | DEFINITIONS. — In this section:<br>(1) Eligible individual with chronic CONDITIONS. —<br>(A) In GENERAL. — Subject to subparagraph (B), the term "eligible individual with chronic conditions" means an individual who —<br>(i) is eligible for medical assistance under the State plan or under a waiver of such plan; and<br>(ii) has at least —<br>(I) 2 chronic conditions;<br>(II) 1 chronic condition and is at risk of having a second chronic condition; or<br>(III) 1 serious and persistent mental health condition. | Iowa chose (III) 1 serious and persistent mental health condition and added Serious Emotional Disturbance. Both require a severe functional impairment documented by a Licensed Mental Health Professional. |
| **Health Homes Enrollment Criteria** | | |
| Consolidated Implementation Guide: Medicaid State Plan – Health Homes | Indicate which one of the following methods will be used to enroll eligible individuals into the Health Homes program. Only one selection may be made.<br>• Opt-in to Health Homes provider<br>• Referral and assignment to Health Homes provider with opt-out | Page 7 Iowa chose opt-in for the IHH SPA. |

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| | • Other | |
| Consolidated Implementation Guide: Medicaid State Plan – Health Homes | Enrollment must be documented by the provider, and that documentation should at a minimum indicate that the individual has received required information explaining the Health Homes program and has consented to receive the Health Homes services noting the effective date of their enrollment. | Pages 7 & 8 General Assurances<br>Pages 23 & 24 under payment. This is in the draft code updates and could include more information under enrollment criteria. |
| Consolidated Implementation Guide: Medicaid State Plan – Health Homes | The state will need to make sure that the Health Homes providers maintain documentation indicating that the individual has, in fact, enrolled and given consent to participate in the Health Homes program. This documentation should, at a minimum, indicate that the individual has received required information explaining the Health Homes program and the date that the individual enrolled in the program. Documentation of the individual's enrollment, and of any subsequent disenrollment, must be maintained in the enrollee's health record by the Health Homes provider. The Health Homes provider should notify the state of the disenrollment and cease Health Homes billing for the disenrolled person. | Pages 7 & 8 General Assurances<br><br>Iowa Medicaid ensures the documentation of the member's enrollment and consent though the chart review workbook.<br><br>Iowa Medicaid also applies MMIS edits that automatically deny claims for disenrolled members.<br><br>The MCOs are contractually required to ensure these requirements are met and applies edits that prevents payment for disenrolled members. |
| **Health Homes Service Delivery Systems** | | |
| SMDL #10-024 dated November 16, 2010; Health Homes FAQs dated May | Health Homes providers must have an infrastructure in place to provide timely, comprehensive, and high-quality Health Home services. Neither the statute nor the SMD letter requires a specific system for delivering Health Homes services under section 1945. Therefore, states are given the flexibility to determine which service delivery system or combination of systems will be used in its Health Homes program. The state may use a fee-for-service, primary care case management | Pages 20-23 describes the Health Homes Service Delivery system. Iowa delivers Health Home services under Fee-For-Services (FFS) and Risk-based managed care through a Team of Heath Care Professionals.<br><br>Pages 16-20 describes the Health Home Provider Standards. |

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| 5, 2012 and December 20, 2015<br><br>Consolidated Implementation Guide: Medicaid State Plan – Health Homes | (PCCM), risk-based managed care delivery system and/or some other model of service delivery. Regardless of the service delivery system, Health Homes providers will need to meet the core Health Homes functional requirements and Health Homes service delivery principles as described under Provider Standards. | |
| | All states with an existing Medicaid managed care delivery system that are implementing a Health Homes program must compare the care coordination activities provided by the health plan to the care coordination activities required for Health Homes in order to avoid duplicative payment for the same service. If the state determines that there is some duplication of activity, the state must take measures to account for that duplication and avoid duplicate payment. The most frequently observed examples seen from approved Health Homes state plans include adjusting the health plan's capitation payment downward to address the duplicative care management activities or imposing additional contract requirements so that the managed care plans perform additional non-duplicative services. | Page 26 IME describes how it ensures non-duplication for similar (1915i Habilitation program and concurrently enrolled in a 1915c waiver program). |
| | Select the service delivery system(s) that will be used for individuals in the Health Homes program from the following list. One service delivery system must be selected and more than one may be selected.<br>• Fee-For-Service<br>• Primary Care Case Management (PCCM)<br>• Risk-Based Managed Care<br>• Other Service Delivery System | Pages 21-23 describes the Health Homes Service Delivery system. Iowa chose FFS and Risk-Based Primary Care. |

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| | If Fee-for-Service is selected, no other information about this service delivery system is requested in this screen. The payment methodology will be described in the Health Homes Payment Methodologies screen. | Pages 21-23 describes the Health Homes Service Delivery system. Checked due to the FFS members that can be enrolled. |
| | If Risk Based Managed Care is selected, indicate Yes or No if the Health Plans will be a Designated Provider or part of a Team of Health Care Professionals. If Yes is selected (Health Plans will be a Designated Provider or part of a Team of Health Care Professionals):<br>• Provide a summary of the contract language imposed on the Health Plans in order to deliver Health Homes services<br>• Check the assurance, "The state provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review."<br>• At your option, upload a copy of the Health Plan contract.<br><br>Select Yes or No whether Health Homes payments will be included in the Health Plan capitation rate. If Yes is selected, check the three assurances displayed.<br>If No is selected, select one or more of the options to indicate which payment methodology(ies) will be used to pay the Health Plans:<br>• Fee-for-Service methodology that is described in the Payment Methodologies screen<br>• Alternative Model of Payment that is described in the Payment Methodologies screen | Pages 21-23 describes the Health Homes Service Delivery system.<br><br>The Health Plan is a part of the Team of Health Care Professionals.<br><br>Pages 8-20 describes the Health Home Provider Standards. Here IME describes roles and responsibilities of health plans versus those of the Health Homes providers.<br><br>Health Plan Contract Language is noted on page 21. |

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| | • Other payment methodology. If other is selected, describe the payment methodology.<br><br>This summary should include an explanation of the roles and responsibilities of health plans versus those of the Health Homes providers. Specifically, it should explain what additional activities the health plans may be providing instead of adjusting the capitation rate. It should also summarize the contract language with respect to the responsibilities of the health plans providing and/or coordinating services with the Health Homes providers. It is preferable that the contract have a separate addendum for Health Homes. | |
| **Health Home Providers – Team of Health Care Professionals** | | |
| Consolidated Implementation Guide: Medicaid State Plan – Health Homes | Section 1945(a) of the Act describes three distinct types of Health Homes provider arrangements from which a beneficiary may receive Health Homes services:<br>• Designated providers, as defined in section 1945(h)(5) of the Act.<br>• A team of health care professionals, which links to a designated provider, as defined in section 1945(h)(6) of the Act.<br>• A health team, as defined in section 1945(h)(7) of the Act. Note that section 1945(h)(7) defines *Health Team* to have the same meaning given *health teams* in section 3502 of the ACA. | Pages 21-23 describes the Health Homes Service Delivery system. Iowa chose Team of Health Care Professionals. |
| Federal Code SEC. 1945. [42 U.S.C. 1396w-4] | **TEAM OF HEALTH CARE PROFESSIONALS**. —The term "team of health care professionals" means a team of health professionals (as described in the State plan amendment) that may — | Pages 8-10<br>**Physicians** At least one MD/DO must be part of the Lead Entity for managed care members and IME for |

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| | (A) include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the State; and<br>(B) be free standing, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary. | fee-for-service members to support the Health Home in meeting the Provider Standards. The MD/DO must have an active Iowa license and be credentialed.<br>**Nurse Care Coordinators** The Lead Entity and the IHH must have Nurse Care Manager(s) to support the Health Home in meeting the Provider Standards and provide oversight of the delivery of Health Home Services to qualified members. The Nurse Care Managers must be a Registered Nurse (RN) or a Bachelor of Science in Nursing (BSN) with an active Iowa license.<br>**Social Workers** The IHH must have Care Coordinator(s) to support the Health Home in meeting the provider standards and deliver Health Home services to qualified members. The Care Coordinator must be a Bachelor of Science in Social Work (BSW), or a Bachelor of Science (BS) or Bachelor of Arts (BA) degree in a related field. The Lead Entity must have a Care Coordinator with a BS/BA in the related field to support the Health Home in meeting the Provider Standards and delivering Health Home Services.<br>**Behavioral Health Professionals** A Psychiatrist must be part of the Lead Entity for managed care enrollees and Iowa Medicaid Enterprise (IME) for fee-for-service enrollees to support the Health Home in meeting the provider standards and to deliver Health Home Services. The Psychiatrist must have a MD/DO and hold an active Iowa license and be credentialed. |
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| Consolidated Implementation Guide: Medicaid State Plan – Health Homes | States will need at a minimum, to include a designated provider or team of health care professionals that includes, employs, contracts with, or otherwise has access to interdisciplinary teams that consist of the following:<br>(1) Primary care physician/nurse practitioner;<br>(2) Nurse;<br>(3) Behavioral health care provider;<br>(4) Social work professional; and<br>(5) Other providers appropriate for the condition of the enrollees.<br><br>For each kind of provider/practitioner the state includes in its Health Homes program, the state will need to describe the qualifications and standards that each must meet in order to participate in its program. | |

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| | | **Peer Support Specialist/Family Support Specialist** The IHH must have either a Peer Support Specialist or Family Support Specialist. Peer Support Specialists and Family Support Peer Specialists must complete a State recognized training and pass the competency exam within six months of hire if not already trained. |
| **Health Home Core Functional Components**<br>**States are expected to describe the infrastructure in place to provide timely, comprehensive, high-quality Health Homes services. The state also will need to describe the methods by which the state will support providers of these services in addressing the following core functional components. (Consolidated Implementation Guide: Medicaid State Plan – Health Homes)** | | |
| Consolidated Implementation Guide: Medicaid State Plan – Health Homes<br><br>SMDL 10-024 Re: Health Homes for Enrollees with Chronic Conditions | Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services. | Pages 11 & 12 IME attests to these. Also located under IHH Provider Standards on pages 16 & 17. |
| | Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines. | |
| | Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders. | |
| | Coordinate and provide access to mental health and substance abuse services. | |
| | Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care. | |

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| | Coordinate and provide access to chronic disease management, including self-management support to individuals and their families. | |
| | Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services. | |
| | Coordinate and provide access to long-term care supports and services. | |
| | Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services. | |
| | Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate. | |
| | Establish a continuous quality improvement program and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level. | |
| **Health Home Service Delivery System Principals:** | | |
| Consolidated Implementation Guide: | Demonstrate clinical competency for serving the complex needs of health home enrollees using evidence-based protocols. | Page 18 **Coordinated/Integrated Care** Incorporate tools and evidenced-based guidelines designed for identifying care opportunities across the age and diagnostic continuum, integrating clinical practices, and coordinating care with other providers. |

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| Medicaid State Plan – Health Homes | Demonstrate the ability for effectively coordinating the full range of medical, behavioral health, long-term services and supports, and social services for medically complex individuals with chronic conditions. | Pages 18 & 19 **Coordinated/Integrated Care**<br>Coordinate or provide access to:<br>○ Mental healthcare<br>○ Oral health<br>○ Long-term care<br>○ Chronic disease management<br>○ Recovery services and social health services available in the community<br>○ Behavior modification interventions aimed at supporting health management (including, but not limited to, obesity counseling, tobacco cessation, and health coaching)<br>○ Comprehensive transitional care from inpatient to other settings, including appropriate follow-up<br>○ Crisis services |
| | Provide health home services that operate under a "whole-person" approach to care using a comprehensive needs assessment and an integrated person-centered care planning process to coordinate care. | Pages 17 & 18 is a board description of Whole-Person Orientation<br>Pages 27 & 28 This is described under **Comprehensive Care Management.**<br><br>*Comprehensive Needs Assessment*<br>• Assessment of the member's current and historical information provided by the member, the Lead Entity, and other health care providers that supports the member.<br>• Assessment includes a physical and behavioral assessment, medication reconciliation, functional limitations, and appropriate |

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| | | screenings, completed by a licensed health care professional within 30 days of enrolling.<br>• Assess the member's social environment so that the plan of care incorporates areas of needs, strengths, preferences, and risk factors.<br>• Assessing member's readiness for self-management using screenings and assessments with standardized tools.<br>• Comprehensive Assessment is conducted at least every 12 months or more frequently as needed when the member's needs or circumstances change significantly or at the request of the member or member's support.<br><br>**Integrated Person-Centered Care Planning Process**<br>• Wraparound planning process: identification, development and implementation of strengths-based individualized person-centered care plans addressing the needs of the whole child and family. |
| | Have conflict of interest safeguards in place to assure enrollee rights and protections are not violated, and that services are coordinated in accordance with enrollee needs expressed in the person-centered care plan, rather than based on financial interests or arrangements of the health home provider. | Page 28 This is described under Comprehensive Care Management.<br><br>**Person-Centered Care plan**<br>Creation of a person-centered care plans by a licensed health care professional with the member and individuals chosen by the member that address the |

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| | | needs of the whole person with input from the interdisciplinary team and other key providers. |
| | Provide access to timely health care 24 hours a day, 7 days a week to address any immediate care needs of their health home enrollees. | Page 19 **Enhanced Access**<br>Assurance of enhanced member and member caregiver (in the case of a child) access, including coverage 24 hours per day, 7 days per week<br>Use of email, text messaging, patient portals and other technology to communicate with members is encouraged<br><br>Page 28 **Comprehensive Care Management**<br>Serve as communication hub facilitating the timely sharing of information across providers 24 hours/day, 7 days/week<br><br>Page 40 **Health Information Technology**<br>Provide 24/7 access to the care team that includes but is not limited to a phone triage system with appropriate scheduling during and after regular business hours to avoid unnecessary emergency room visits and hospitalizations. |
| | Have in place operational protocol, as well as communication procedures to assure care coordination across all elements of the health care system (hospitals, specialty providers, social service providers, other community-based settings, etc.). | IME will ensure this is met through a Self-Assessment<br>Pages 18 & 19 **Coordinated/Integrated Care** (Standards)<br>Pages 29 & 30 **Care Coordination**<br><br>Care Coordination includes assisting members with medication adherence, appointments, referral |

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| | | scheduling, understanding health insurance coverage, reminders, and transition of care, wellness education, health support and/or lifestyle modification, and behavior changes. Coordinate, direct, and ensure results are communicated back to the IHH. |
| | Have protocols for ensuring safe care transitions, including established agreements and relationships with hospitals and other community-based settings. | IME will ensure this is met through a Self-Assessment Pages 17 & 18<br><br>Whole Person Orientation<br>○ Work with the Lead Entity or IME to develop capacity to receive members redirected from emergency departments, engage in planning transitions in care with area hospitals, and to follow-up on hospital discharges, including Psychiatric Medical Institutions for Children (PMIC).<br>○ Have evidence of bi-directional and integrated primary care/behavioral health services through use of a contract, memoranda of agreement or other written agreements approved by the State.<br>○ Provide letters of support from at least one area hospital and two area primary care practices that agree to collaborate with the IHH on care coordination and hospital/ER notification. |
| | Establish a continuous quality improvement program that includes a process for collection and reporting of health home data for quality monitoring and program performance; permits evaluation of increased coordination and chronic disease | IME will ensure this is met through a Self-Assessment IME supports the Health Home through a Learning Collaborative. |

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| | management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level. | Page 11 IME attests to providing support for Health Home Providers.<br>Establish a continuous quality improvement program and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.<br><br>Page 15 Provider Standards (Same statement as above)<br><br>Pages 19 & 20 Provider Standards<br>Emphasis on Quality and Safety<br>○ An ongoing quality improvement plan to address gaps and opportunities for improvement.<br>○ Participate in ongoing process improvement on clinical indicators and overall cost effectiveness specified by and reported to the State.<br>○ Demonstrate continuing development of fundamental Health Home functionality through an assessment process to be applied by the State.<br>○ Have strong, engaged organizational leadership who are personally committed to and capable of:<br>▪ Leading the practice through the transformation process and sustaining transformed practice. |

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| | | ▪ Agreeing to participate in learning activities including in person sessions, webinars, and regularly scheduled phone calls.<br>○ Agree to participate in or convene ad hoc or scheduled meetings to plan and discuss implementation of goals and objectives for practice transformation with ongoing consideration of the unique practice needs for adult members with SMI and child members with SED and their families.<br>○ Participate in CMS and State required evaluation activities.<br>○ Submit reports as required by the State (e.g., describe IHH activities, efforts, and progress in implementing IHH services).<br>○ Maintain compliance with all the terms and conditions as an IHH provider.<br>○ Commit to the use of an interoperable patient registry and certified Electronic Health Record (EHR) within a timeline approved by the Lead Entity or IME, to input information such as annual metabolic screening results, and clinical information to track and measure care of members, automate care reminders, and produce exception reports for care planning.<br>○ Complete web-based member enrollment, disenrollment, members' consent to release to information, and health risk questionnaires for all members. |

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| | | ○ Demonstrate use of a certified EHR to support clinical decision making within the practice workflow.<br>○ Demonstrate evidence of acquisition, installation, and adoption of an EHR system and establish a plan to meaningfully use health information in accordance with the federal law.<br>○ Implement state required disease management programs based on population-specific disease burdens. Individual Health Homes may choose to identify and operate additional disease management programs at any time. |
| | Use data for population health management, tracking tests, referrals and follow-up, and medication management. | IME will ensure this is met through a Self-Assessment<br>Page 19 Provider Standards Coordinated/Integrated Care<br>• Maintain system and written standards and protocols for tracking member referrals<br><br>Pages 29 & 30 Care Coordination<br>• Making referrals<br>• Tracking referrals and appointments<br>• Follow-up monitoring<br><br>The establishment of an EHR system will assist care coordinators with maintaining a comprehensive medication list, allow providers access to evidenced-based decisions and assist with referral protocols. |

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| | | Pages 36 & 37 Referral to Community and Social Support Services<br><br>Provide resource referrals or coordinate to the following, as needed:<br>• Resources to reduce barriers to assist members in achieving their highest level of function with independence.<br>• Primary care providers and specialists<br>• Wellness programs, including tobacco cessation, fitness, nutrition or weight management programs, and exercise facilities or classes.<br>• Specialized support groups (i.e., cancer or diabetes support groups, NAMI psychoeducation).<br>• School supports.<br>• Substance treatment links in addition to treatment -- supporting recovery with links to support groups, recovery coaches, and 12-step programs.<br>• Iowa Department of Public Health (IDPH) Programs.<br>• Housing services Housing and Urban Development (HUD), rental assistance program through the Iowa Finance authority.<br>• Food Assistance Iowa Department of Human Services (DHS), Food Bank of Iowa. |

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| | | • Transportation services (NEMT), free or low-cost public transportation.<br>• Programs that assist members in their social integration and social skill building.<br>• Faith-based organizations.<br>• Employment and educational programs or training, Iowa Workforce Development.<br>• (IWD), Iowa Vocational Rehab Services (IVRS),<br>• Volunteer opportunities.<br>• Monitor and follow-up with referral source, member, and member's support to ensure that members are engaged with the service. |
| | Use health information technology to link services and facilitate communication among interdisciplinary team members and other providers to coordinate care and improve service delivery across the care continuum. | IME will ensure this is met through a Self-Assessment Page 40<br><br>As a part of the minimum requirements of an eligible provider to operate as a Health Home, the following relate to HIT:<br>• Demonstrate use of a population management tool (patient registry) and the ability to evaluate results and implement interventions that improve outcomes over time.<br>• Demonstrate evidence of acquisition, instillation, and adoption of an EHR, system and establish a plan to meaningfully use health information in accordance with federal law. |

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| | | • Provide 24/7 access to the care team that includes but is not limited to a phone triage system with appropriate scheduling during and after regular business hours to avoid unnecessary emergency room visits and hospitalizations.<br>• Utilize email, text, messaging, patient portals and other technology as available to communicate with other providers. |
| **Health Home Qualification Standards** | | |
| Federal Code SEC. 1945. **[**42 U.S.C. 1396w-4**]** | HEALTH HOME QUALIFICATION STANDARDS. —The Secretary shall establish standards for qualification as a designated provider for the purpose of being eligible to be a health home for purposes of this section. | IME will ensure this is met through a Self-Assessment Begins on Page 8 of the SPA and outlines the qualifications and standards. |
| SMDL 10-024 Re: Health Homes for Enrollees with Chronic Conditions | Provider Standards: States will be expected to develop a health home model of service delivery that has designated providers operating under a "whole-person" approach to care within a culture of continuous quality improvement. A whole-person approach to care looks at all the needs of the person and does not compartmentalize aspects of the person, his or her health, or his or her well-being. We expect providers of health home services to use a person-centered planning approach to identifying needed services and supports, providing care and linkages to care that address all the clinical and non-clinical care needs of an individual. | IME will ensure this is met through a Self-Assessment Begins on Page 8 of the SPA and outlines the qualifications and standards.<br><br>Whole-person approach (Pages 17-19)<br>Whole Person Orientation<br>○ Provide or take responsibility for appropriately arranging care with other qualified professionals for all the member's health care needs. This includes care for all stages of life, acute care, chronic care, preventive services, long-term care, and end of life care. |

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| | | ○ Complete status reports to document member's housing, legal, employment status, education, custody, etc.<br>○ Implement a formal screening tool to assess behavioral health (mental health and substance abuse) treatment needs along with physical health care needs.<br>○ Work with the Lead Entity or IME to develop capacity to receive members redirected from emergency departments, engage in planning transitions in care with area hospitals, and to follow-up on hospital discharges, including Psychiatric Medical Institutions for Children (PMIC).<br>○ Have evidence of bi-directional and integrated primary care/behavioral health services through use of a contract, memoranda of agreement or other written agreements approved by the State.<br>○ Provide letters of support from at least one area hospital and two area primary care practices that agree to collaborate with the IHH on care coordination and hospital/ER notification.<br>○ Advocate in the community on behalf of their IHH members as needed. |

| Health Homes Payment Methodologies | | |
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| Federal Code SEC. 1945. [42 U.S.C. 1396w-4] | A State shall provide a designated provider, a team of health care professionals operating with such a provider, or a health team with payments for the provision of health home services to each eligible individual with chronic conditions that selects such provider, team of health care professionals, or health team as the individual's Health Home. | This SPA is Team of Health Care Professionals. |
| Federal Code SEC. 1945. [42 U.S.C. 1396w-4] | The State shall specify in the State plan amendment the methodology the State will use for determining payment for the provision of health home services. Such methodology for determining payment—<br>(i) may be tiered to reflect, with respect to each eligible individual with chronic conditions provided such services by a designated provider, a team of health care professionals operating with such a provider, or a health team, as well as the severity or number of each such individual's chronic conditions or the specific capabilities of the provider, team of health care professionals, or health team; and<br>(ii) shall be established consistent with section 1902(a)(30)(A). https://www.ssa.gov/OP_Home/ssact/title19/1902.htm | Pages 23-27<br>IME uses a tiered approach based on adult/child Habilitation/Children's Mental Health Waiver. |
| Consolidated Implementation Guide: Medicaid State Plan – Health Homes | Health Homes rates must be based on Health Homes units of service, whether on a fee-for service basis, a per member per month (PMPM) basis, or another approved methodology. These rates may reflect any service overhead costs. Separate payments, apart from payment for Health Homes services rendered, may not be made for such costs. The Health Homes payment methodology should include a description of how the state will review the rates and rebase, if necessary. This should include an explanation of the factors that will be reviewed (such | Pages 25-26<br>**Rate Development**<br>1) **In the SPA, please provide the cost data and assumptions that were used to develop each of the rates**. The rate is developed according to the actual cost of providing each component of the service for the adult population with and without intensive care management and the child population with and without |

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| | as staff salaries and other cost data) and the state's procedures and timetable (at least annually) for reviewing the rates to ensure that they remain economic and efficient and ensure the provision of quality care. | intensive care management service. No other payments for these services shall be made.<br><br>Salaries are pulled from Iowa Wage Report data (https://www.iowaworkforcedevelopment.gov/iowa-wagereport) using applicable codes for each individual role. Costs were allocated based on caseloads and enrollment, with budget neutrality.<br><br>2) **Please identify the reimbursable unit(s) of service**<br>• Tier 5 Adults<br>• Tier 6 Children<br>• Tier 7 Habilitation<br>• Tier 8 Children' Mental Health Waiver<br><br>3) **Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit.** The minimum service is that the Provider document one of the six Health Home Services.<br><br>4) **Please describe the state's standards and process required for service documentation.** All Health Home Services must be documented in the member record and identified with a specific code on the claim. |
| Consolidated Implementation Guide: Medicaid State Plan – Health Homes | **Agency Rates**<br>If Fee for Service was selected as a payment methodology, the Agency Rates section must be completed. Select one option which best describes the rates used from the following:<br>• FFS rates included in the plan.<br>• Comprehensive methodology included in the plan.<br>• The agency rates are set as of the following date and are effective for services provided on or after that date.<br>o If this is selected:<br>▪ Enter the effective date<br>▪ Enter the website where the rates are displayed<br><br>Note: If the fee-for-service rates are not displayed on a website, they should be entered above in the text box for the description of variation of fee-for-service rates. | |
| | **Rate Development**<br>If Fee for Service was selected as a payment methodology, the Rate Development section must be completed. Provide a comprehensive description of the manner in which rates were set, which must include:<br>• Cost data and assumptions used to develop each of the rates.<br>• Reimbursable units of service.<br>• Minimum level of activities required for providers to receive payment per the defined unit. | |

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| | • Standards and process required for service documentation<br>• Procedures for reviewing and rebasing the rates, including:<br>o Frequency of review<br>o Factors that will be reviewed in order to understand if the rates are economic, efficient and sufficient to ensure quality services. | 5) **Please describe in the SPA the procedures for reviewing and rebasing the rates, including**<br>**• The frequency with which the state will review the rates, and**<br>**• The factors that will be reviewed by the state in order to understand if the rates are economic, efficient, and sufficient to ensure quality services. The rates will be reviewed on an annual basis using the same methodology described in this section.**<br><br>The rates will be reviewed on an annual basis using the same methodology described in this section. |
| **Health Home Services - Health Homes must provide all six of the required Health Homes services, based on the individual's needs as appropriate:** | | |
| Federal Code SEC. 1945. **[**42 U.S.C. 1396w-4**]** | HEALTH HOME SERVICES. —<br><br>(A) IN GENERAL. —The term "health home services" means comprehensive and timely high-quality services described in subparagraph (B) that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team.<br><br>(B) SERVICES DESCRIBED. —The services described in this subparagraph are—<br>(i) comprehensive care management; | IME will ensure this is met through a Self-Assessment and Chart Review.<br><br>Pages 27-38 describe in detail each of the Health Home Services along with the expectation of each member of the team and HIT requirements. |

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| | (ii) care coordination and health promotion;<br>(iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;<br>(iv) patient and family support (including authorized representatives).<br>(v) referral to community and social support services, if relevant; and<br>(vi) use of health information technology to link services, as feasible and appropriate. | |
| Consolidated Implementation Guide: Medicaid State Plan – Health Homes | State is required to define the six types of Health Homes services that are statutorily required to be provided by each Health Homes provider arrangement and covered under the Health Homes benefit. The state also will describe how health information technology will be used to link each Health Homes service in a comprehensive approach across the care continuum, including a flow chart illustrating how Health Homes services will be integrated into the overall care received by the beneficiary. | |
| | **Comprehensive Care Management**<br>Comprehensive Care Management means the initial and ongoing assessment and care management services aimed at the integration of primary, behavioral and specialty health care and community support services, using a comprehensive person-centered care plan which addresses all clinical and non-clinical needs and promotes wellness and management of chronic conditions in pursuit of optimal health outcomes. Comprehensive care management services include, but are not limited to the following activities: | IME will ensure this is met through a Self-Assessment and Chart Review<br>Pages 27-29 |

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| | • Conducting outreach and engagement activities to gather information from the enrollee, the enrollee's support member(s), and other primary and specialty care providers.<br>• Completing a comprehensive needs assessment.<br>• Developing a comprehensive person-centered care plan.<br>• The comprehensive assessment includes current and historical information provided by the enrollee, as well as information received from available health care records, input received through consultation with other health care providers and the enrollee's support member, and assessments performed by telemedicine or other information technology medium as appropriate.<br>• The comprehensive assessment includes a physical examination, behavioral assessment, medication reconciliation, functional limitations, screenings as deemed appropriate, assessment of clinical and social support needs, and any "at risk" concerns. Information received from the comprehensive assessment then serves as the basis for the person-centered care plan.<br>• The comprehensive needs assessment should be conducted at least every 12 months (or more frequently as needed), when the individual's needs or circumstances change significantly, or at the request of the enrollee or the enrollee's support member. | |
| Consolidated Implementation Guide: | **Care Coordination**<br>Care Coordination means facilitating access to, and the monitoring of, services identified in a person-centered care plan to manage chronic conditions for optimal health outcomes and to promote wellness. Care coordination includes the | IME will ensure this is met through a Self-Assessment and Chart Review.<br>Pages 29-31 |

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| Medicaid State Plan – Health Homes | facilitation of the interdisciplinary teams to perform a regular review of person-centered care plans and monitoring service delivery and progress toward goals. This is accomplished through face-to-face and collateral contacts with the Health Homes enrollee, family, informal and formal caregivers, and with primary and specialty care providers. It also includes facilitation and sharing of centralized information to coordinate integrated care by multiple providers through use of electronic health records (EHRs) that can be shared among all providers. Care coordination services include, but are not limited to, the following activities:<br>• Implementing the person-centered care plan.<br>• Continuous monitoring of progress towards goals identified in the person-centered care plan through face-to-face and collateral contacts with enrollee, enrollee's support member(s) and primary and specialty care providers.<br>• Supporting the enrollee's adherence to prescribed treatment regimens and wellness activities.<br>• Participating in hospital discharge processes to support the enrollee's transition to a non-hospital setting.<br>• Communicating and consulting with other providers and the enrollee and enrollee's support member, as appropriate.<br>• Facilitating regularly scheduled interdisciplinary team meetings to review care plans and assess progress. The person-centered care plan serves as the basis for the coordination of care among Health Homes providers. The Health Homes interdisciplinary team develops a person-centered care plan jointly with each Health Homes enrollee consistent with §441.725. | |

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| | The care plan is to be developed by a licensed health care professional for the Health Homes program, in collaboration with the Health Homes enrollee, and individuals chosen by the enrollee to serve as contributors to the planning process. In addition, it must include input from an interdisciplinary team and other key providers (the individual's primary care physician, nurse care manager, behavioral health providers, social work professionals and other providers as appropriate) to assess and evaluate the health, behavioral health, and long-term services and supports, as well as the social needs of the participant. The proposed requirements for the person-centered care plan are consistent with those required in the January 16, 2014, HCBS final rule. We expect that the person-centered care plan reflects what is important to the individual and important for his or her health and welfare and is developed at a time and location of convenience to the Health Homes enrollee. The plan reflects the Health Homes enrollee's values and preferences, and current and long term needs and goals for care and specifies the types and frequency of all planned health, rehabilitation, behavioral health treatments, medications, home care services and supports and other services as needed. The plan also identifies who is responsible for providing each service and any areas that may require further follow up or revisions to the plan. The plan must be accessible to the Health Homes enrollee and the Health Homes team. | |
| Consolidated Implementation Guide: | **Health Promotion**<br>Health Promotion means the education and engagement of an individual in making decisions that promote his/her maximum independent living skills and lifestyle choices that achieve the | IME will ensure this is met through a Self-Assessment and Chart Review.<br>Pages 31-33 |

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| Medicaid State Plan – Health Homes | following goals: good health, pro-active management of chronic conditions, early identification of risk factors, and appropriate screening for emerging health problems. Health promotion services include, but are not limited to, the following activities:<br>• Promoting enrollee's education of their chronic condition.<br>• Teaching self-management skills.<br>• Conducting medication reviews and regimen compliance.<br>• Promoting wellness and prevention programs by assisting Health Homes enrollees with resources that address exercise, nutrition, stress management, substance use reduction/cessation, smoking cessation, self-help recovery resources, and other wellness services based on enrollee needs and preferences. | |
| Consolidated Implementation Guide: Medicaid State Plan – Health Homes | **Comprehensive Transitional Care** from Inpatient to Other Settings (including appropriate follow-up) Comprehensive Transitional Care means the facilitation of services for the individual and family/caregiver when the individual is transitioning between levels of care (including, but not limited to hospital, nursing facility, rehabilitation facility, community-based group home, family, or self-care) or when an individual is electing to transition to a new Health Homes provider. This involves developing relationships with hospitals and other institutions and community providers to ensure and to foster the efficient and effective care transitions. Health Homes should establish a written protocol on the care transition process with hospitals (and other community-based facilities) to set up real time sharing of information and care transition records for Health Homes enrollees. | IME will ensure this is met through a Self-Assessment and Chart Review.<br>Pages 33-35 |

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| | Comprehensive transitional care services include, but are not limited to, the following activities:<br>• Establishing relationships with hospitals, residential settings, rehabilitation settings, other treatment settings, and long-term services and supports providers to promote a smooth transition if the enrollee is moving between levels of care and back into the community.<br>• This includes prompt notification and ongoing communication of enrollee's admission and/or discharge to and from an emergency room, inpatient residential, rehabilitative, or other treatment settings.<br>• If applicable, this relationship should also include active participation in discharge planning with the hospital or other treatment settings to ensure consistency in meeting the goals of the enrollee's person-centered care plan.<br>• Communicating and providing education to the enrollee, the enrollee's support member and the providers that are located at the setting from which the person is transitioning, and at the setting to which the individual is transitioning.<br>• Developing a systemic protocol to assure timely access to follow-up care post discharge that includes at a minimum all of the following:<br>  ○ Receipt of a summary of care record from the discharging entity.<br>  ○ Medication reconciliation.<br>  ○ Reevaluation of the care plan to include and provide access to needed community support services.<br>• A plan to ensure timely scheduled appointments. | |

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| Consolidated Implementation Guide: Medicaid State Plan – Health Homes | **Individual and Family Support (which includes authorized representatives)**<br>Individual and family supports mean the coordinating of information and services to support enrollees and the enrollee's support members to maintain and promote the quality of life, with particular focus on community living options. Individual and family support services include, but are not limited to, the following activities:<br>• Providing education and guidance in support of self-advocacy.<br>• Providing caregiver counseling or training to include, skills to provide specific treatment regimens to help the individual improve function, obtain information about the individual's disability or conditions, and navigation of the service system.<br>• Identifying resources to assist individuals and family support members in acquiring, retaining, and improving self-help, socialization, and adaptive skills.<br>○ Providing information and assistance in accessing services such as: self-help services, peer support services; and respite services. | IME will ensure this is met through a Self-Assessment and Chart Review.<br>Pages 35-36 |
| Consolidated Implementation Guide: Medicaid State Plan – Health Homes | **Referral to Community and Social Support Services**<br>Referral to community/social supports means the provision of information and assistance for the purpose of referring enrollees and enrollee support members to community-based resources, regardless of funding source, that can meet the needs identified on the enrollee's person-centered care plan. Referrals to community/social support services include, but are not limited to, the following activities: | IME will ensure this is met through a Self-Assessment and Chart Review.<br>Pages 36-38 |

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| | • Providing referral and information assistance to individuals in obtaining community based resources and social support services.<br>• Identifying resources to reduce barriers to help individuals in achieving their highest level of function and independence.<br>• Monitoring and follow up with referral sources, enrollee, and enrollee's support member, to ensure appointments and other activities, including employment and other social community integration activities, were established and enrollees were engaged in services. | |
| **Health Homes Monitoring** | | |
| Federal Code SEC. 1945. **[**42 U.S.C. 1396w-4**]** | MONITORING. —A State shall include in the State plan amendment—<br><br>(1) a methodology for tracking avoidable hospital readmissions and calculating savings that result from improved chronic care coordination and management under this section; and<br><br>(2) a proposal for use of health information technology in providing health home services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider). | IME will ensure this is met through Analytics<br>Page 39 (1)<br>Pages 39-40 (2) |
| Consolidated Implementation Guide: | States should collect, track/monitor and report specific types of information and data for evaluation purposes that are statutorily required for the Health Homes benefit. This information and data also will be used to inform stakeholders including the | IME will ensure this is met through Analytics<br>Savings Methodology outlined Page 39<br>Medicare Data is not used. |

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| Medicaid State Plan – Health Homes | state, CMS, and Congress about the success of the Medicaid Health Homes program in improving the coordination and quality of health care for the beneficiary with chronic conditions while reducing costs. The information and data collected and reported also will be used to inform and assist in the continuous improvement of the state's Health Homes program/model. | |
| | Describe the state's methodology for calculating cost saving. The description should include:<br>• Savings resulting from improved coordination of care and chronic disease management, including data sources and measurement specifications.<br>• Savings associated with serving dual-eligible, including if Medicare data was available to the state and used in calculating the estimate. | |
| | **Cost Savings Methodology:** The state's description for calculating cost savings should be sufficiently clear, detailed, and complete to permit the reviewer to determine that the state's election meets applicable federal statutory, regulatory and policy requirements. It should include the methodology used to calculate savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligible, and if Medicare data was available to the state to utilize in arriving at its cost savings estimates. | |

| Health Homes Quality Measurement and Evaluation | | |
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| Consolidated Implementation Guide: Medicaid State Plan – Health Homes | Check the four assurances related to:<br>• Requiring providers to report to the state all applicable quality measures as a condition of receiving payment.<br>• Identifying measurable goals and quality measures for each goal.<br>• Reporting information to CMS.<br>• Tracking avoidable hospital readmissions and reporting annually in the Quality Measures report. | Currently IME Does not ask Health Homes for information to report quality measures.<br>• Currently in development. Page 5 outlines goals and objectives.<br>• Currently in development. Pages 38 & 39 |
| | **Use of Health Information Technology:** The state's description for using health information technology in providing Health Homes services should be sufficiently clear, detailed, and complete to permit the reviewer to determine that the state's election meets applicable federal statutory, regulatory and policy requirements. It should include the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider. | Pages 39 & 40, also under each Health Home Service. |
| SMDL 10-024 Re: Health Homes for Enrollees with Chronic Conditions<br>SMDL 10-024 Re: Health Homes for Enrollees with | CMS expects States to collect and report information required for the overall evaluation of the health home model of service delivery and recommends that States collect individual-level data for the purposes of comparing the effect of this model across sub-groups of Medicaid beneficiaries, including those that participate in the health home model of service delivery and those that do not. This evaluation, and the data gathered for it, will provide States with information that can help inform continued improvement of a state's health home model. | The Lead Entity will provide technology infrastructure for health information exchange to be utilized by the Health Homes to facilitate collaboration. These capabilities include but are not limited to; member screening and risk stratification, and a web-based profile that integrates Medicaid claims, member self-reported information, and clinical documentation. The Lead Entity will be responsible for sharing health utilization and claims data with the Health Homes to facilitate care coordination and prescription monitoring for members receiving Health Home services. A |

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| Chronic Conditions | | member website will be available to Health Home enrollees, their families, and supports. It will contain evidence-based information on conditions, health promotion and wellness information, and links to resources.<br><br>As a part of the minimum requirements of an eligible provider to operate as a Health Home, the following relate to HIT:<br>• Demonstrate use of a population management tool (patient registry) and the ability to evaluate results and implement interventions that improve outcomes over time.<br>• Demonstrate evidence of acquisition, instillation, and adoption of an EHR, system and establish a plan to meaningfully use health information in accordance with federal law.<br>• Provide 24/7 access to the care team that includes but is not limited to a phone triage system with appropriate scheduling during and after regular business hours to avoid unnecessary emergency room visits and hospitalizations.<br>• Utilize email, text, messaging, patient portals and other technology as available to communicate with other providers. |

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| | As part of the focus on continued improvement and evaluation, section 1945(f) of the Act requires States that implement these health homes to track avoidable hospital readmissions, calculate cost savings that result from improved coordination of care and chronic disease management, and monitor the use of health information technology to improve service delivery and coordination across the care continuum (including the use of wireless patient technology in improving coordination, management of care, and patient adherence to recommendations made by their providers). For the purposes of the overall evaluation, States are also expected to track emergency room visits and skilled nursing facility admissions. | Page 38 for avoidable hospital readmissions and cost savings.<br><br>**We do not do the following**: monitor the use of health information technology to improve service delivery and coordination across the care continuum (including the use of wireless patient technology in improving coordination, management of care, and patient adherence to recommendations made by their providers).<br><br>Page 40 & 41 States are also expected to track emergency room visits and skilled nursing facility admissions. |
| Federal Code SEC. 1945. **[**42 U.S.C. 1396w-4**]** | REPORT ON QUALITY MEASURES. —As a condition for receiving payment for health home services provided to an eligible individual with chronic conditions, a designated provider shall report to the State, in accordance with such requirements as the Secretary shall specify, on all applicable measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the State with such information. | The Health Homes are not required by IME to report on any measures for determining quality of services except for the Chart Review Workbook to ensure Health Home Service documentation and planned Self-Assessment to ensure that policies and processes are in place to provide Health Home Services. |
| SMDL 13-001 Re: Health Home Core Quality Measures. | The health homes core set of quality measures will be used to evaluate care across all state health home programs. CMS expects that states will report on the health home core measures, as well as the specific goals and measures identified by individual states. The intent of the two-part quality reporting approach is to gain consistency across states while | IME submits measures to CMS through MacPRO. IME doesn't submit information on the goals. |

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| | allowing states to use existing quality metrics to measure health home outcomes. All of the quality data will be utilized by CMS to work with states and other stakeholders to continually improve health homes. The data will also be used to inform the evaluations that section 2703 of the Affordable Care Act. | |

## References

- Consolidated Implementation Guide: Medicaid State Plan – Health Homes

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- Health Home Information Resource Center: Health Home Information Resource Center | Medicaid
- Federal Code: Social Security Act §1945 (ssa.gov)
- SMDL 10-024 Re: Health Homes for Enrollees with Chronic Conditions: SMD10024.pdf (medicaid.gov)
- SMDL 13-001 Re: Health Home Core Quality Measures: state-medicaid-director-letter-1-13.pdf
- Integrated Health Homes SPA 2022: https://dhs.iowa.gov/sites/default/files/Integrated_Health_Homes_SPA_2022_0.pdf?012020221647
- IA-22-0004 (CMS State Plan Print View) Integrated Health Homes SPA: https://dhs.iowa.gov/sites/default/files/Medicaid_State_Plan_Print_View%20IA-22-0004-IHH.pdf?011420221951